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INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11257

## 1126 CERTIFICATE OF DEATH

Reg. Dist. No. 100

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <i>Chas</i>		MARYLAND		STATE <i>md</i>		COUNTY <i>Chas</i>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <i>La Plata</i>		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>La Plata</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Physician Mem. Hosp</i>				STREET ADDRESS (If rural give location)			
<b>3. NAME OF DECEASED</b> (Type or Print) <i>Maria Asamuth BERRY</i>				<b>4. DATE OF DEATH</b> (Month) <i>Nov</i> (Day) <i>24</i> (Year) <i>1956</i>			
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Single</i>	8. DATE OF BIRTH <i>Aug 20 1876</i>	9. AGE last birthday <i>80</i> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housework</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Self</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>George W Berry</i>				14. MOTHER'S MAIDEN NAME <i>Mary Jane Cox</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <i>No</i>		16. SOCIAL SECURITY NO. <i>None</i>		17. INFORMANT & ADDRESS <i>Walter W Berry La Plata Md</i>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
581.0 IMMEDIATE CAUSE (A) <i>Cirrhosis of Liver</i>				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST. DUE TO (C)							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
<b>22. I hereby certify</b> that I attended the deceased from <i>11-21-56</i> , 19 <i>56</i> , to <i>11-24-56</i> , 19 <i>56</i> , that I last saw the deceased alive on <i>11-21-56</i> , 19 <i>56</i> , and that death occurred at <i>3 P</i> M, from the causes and on the date stated above.							
SIGNATURE <i>E. H. Haden</i>		M.D.		ADDRESS (Street, city, town, state) <i>La Plata Md</i>		DATE SIGNED <i>11-24-56</i>	
23. BURIAL CREMATION, REMOVAL (SPECIFY) <i>Burial</i>	DATE THEREOF <i>11-27-56</i>	NAME OF CEMETERY OR CREMATORY <i>MT Rest</i>		LOCATION (City, town, or county) (State) <i>La Plata Md</i>			
24. REC'D BY REGISTRAR	REGISTRAR'S SIGNATURE <i>Julia F. Posey</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>Hunt Funeral Home</i>		ADDRESS <i>Waldorf Md</i>		
DATE <i>NOV 28 1956</i>							

# CERTIFICATE OF DEATH

Reg. Dist. No.

1. LOCAL RESIDENCE (NUMBER OF DECEASED)

2. PLACE OF DEATH

DECEASED

SEX

AGE

DATE

TIME

CAUSE

OF

DEATH

3. CAUSE OF DEATH

4. PLACE OF DEATH

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BUREAU V. S.

NOV 28 1956

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 4 Film 207 11-29-56 et

## CERTIFICATE OF DEATH

11258

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Chas</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Chas</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>—</u>		d. STREET ADDRESS <u>—</u>	
3. NAME OF DECEASED (Type or print) <u>Gordon</u> First <u>Anthony</u> Middle <u>Datcher</u> Last		4. DATE OF DEATH <u>November</u> Month <u>20</u> , Day <u>19</u> Year <u>56</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>OCT 2, 1956</u>
9. AGE (In years last birthday) yrs. <u>1</u> Months <u>10</u> Days <u>20</u> Hours <u>—</u> Min. <u>—</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>—</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>—</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Chesler A. Datcher.</u>		14. MOTHER'S MAIDEN NAME <u>Lillian MAKLE</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> (If yes, give war or dates of service) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Lillian Datcher</u> Address <u>Waldorf, Md.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Branch of the cancer</u> <u>491X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>—</u> DUE TO (c) <u>—</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>7</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>—</u>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Nov 18</u> , 19 <u>55</u> , to <u>Nov 20</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>Nov 4</u> , 19 <u>54</u> , and that death occurred at <u>5 P</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Harry R. Coburn</u> M.D.		DATE SIGNED <u>Nov 26</u>	
PHYSICIAN'S NAME (Type) <u>Harry R. Coburn</u>		<u>Bryantown, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Nov 21 1956</u>	22c. NAME OF CEMETERY OR CREMATORY <u>H. Marys</u>	22d. LOCATION (City, town, or county) (State) <u>Bryantown Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hunt Funeral Home</u> ADDRESS <u>Waldorf Md</u>		24a. REC'D BY REGISTRAR <u>NOV 26 1956</u>	
24b. REGISTRAR'S SIGNATURE <u>Julia Poy</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED <i>Charles A. Butcher</i>		2. SEX <i>Male</i>	
3. AGE <i>38</i>		4. DATE OF BIRTH <i>July 1, 1921</i>	
5. PLACE OF BIRTH <i>Washington, D.C.</i>		6. OCCUPATION <i>Butcher</i>	
7. MARITAL STATUS <i>Married</i>		8. DATE OF MARRIAGE <i>June 1, 1945</i>	
9. NAME OF SPOUSE <i>William H. Butcher</i>		10. DATE OF DEATH <i>Nov 26, 1956</i>	
11. PLACE OF DEATH <i>Home</i>		12. CAUSE OF DEATH <i>Heart Disease</i>	
13. MEDICAL HISTORY <i>None</i>		14. SIGNATURE OF PHYSICIAN <i>[Signature]</i>	
15. SIGNATURE OF REGISTRAR <i>[Signature]</i>		16. OFFICIAL USE	

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NOV 26 1956

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# 1 M X 00 0 0 1 0 1 VS A15 (4) 15M 9/55 100 11259 11266 100 Reg. Dist. No. 11259 100 11259 11266 CERTIFICATE OF DEATH 1. PLACE OF DEATH a. COUNTY Charles MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) La Plata (rural) c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION none 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Charles c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) La Plata (rural) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES ☐ NO ☒ 3. NAME OF DECEASED (Type or print) First Middle Last Mary Josephine Hill 4. DATE OF DEATH Month Day Year November 27 1956 5. SEX F 6. COLOR OR RACE W 7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ 8. DATE OF BIRTH June 1 1879 9. AGE (In years last birthday) yrs. 77 IF UNDER 1 YEAR Months Days Hours Min. 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) house work 10b. KIND OF BUSINESS OR INDUSTRY self 11. BIRTHPLACE (State or foreign country) Maryland 12. CITIZEN OF WHAT COUNTRY? US 13. FATHER'S NAME William J. Hawkins 14. MOTHER'S MAIDEN NAME Mary Toye 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service) 16. SOCIAL SECURITY NO. none 17. INFORMANT Gertrude Short Address Washington, D.C. 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 331x Cerebral Hemorrhage DUE TO (b) Hypertension DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 5 days 3 yrs PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒ 20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 20d. INJURY OCCURRED While at work ☐ Not while at work ☐ 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that I attended the deceased from 11/22, 1956, to 11/27, 1956, that I last saw the deceased alive on 11/26, 1956, and that death occurred at 4:30 A. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE Frank A. Susan M.D. Indian Head, Md. 11/27/56 PHYSICIAN'S NAME (Type) Frank A. Susan M.D. 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF 11-29-56 22c. NAME OF CEMETERY OR CREMATORY St. Josephs Cemetery 22d. LOCATION (City, town, or county) (State) Pomfret, Maryland 23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Hunt Funeral Home Waldorf, Md. 24a. REC'D BY REGISTRAR DATE NOV 30 1956 24b. REGISTRAR'S SIGNATURE Julia Posey



CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. OCCUPATION	
JAMES H. HARRIS		Male		45		White		Farmer	
6. PLACE OF BIRTH		7. DATE OF BIRTH		8. DATE OF DEATH		9. TIME OF DEATH		10. PLACE OF DEATH	
Maryland		Jan 15, 1900		Jan 15, 1956		10:30 AM		Home	
11. CAUSE OF DEATH		12. MANNER OF DEATH		13. PLACE OF INTERMENT		14. NAME OF FUNERAL HOME		15. NAME OF MINISTER	
Heart Disease		Natural		Catholic Cemetery		St. Mary's		Rev. J. J. Smith	
16. SIGNATURE OF PHYSICIAN		17. SIGNATURE OF DECEASED		18. SIGNATURE OF WITNESSES		19. SIGNATURE OF FUNERAL HOME		20. SIGNATURE OF MINISTER	
J. J. Smith				J. J. Smith, J. J. Smith		St. Mary's		Rev. J. J. Smith	

BUREAU V. S.

NOV 30 1956

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 11260  
11267 CERTIFICATE OF DEATH

Reg. Dist. No. 106

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY Charles	MARYLAND	STATE Maryland	COUNTY Charles
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN Indian Head, Maryland	LENGTH OF STAY (in this place) 1yr 9mos	CITY (If outside corporate limits, write RURAL and give nearest town) OR Naval Powder Factory TOWN Indian Head, Maryland	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Naval Powder Factory Indian Head, Maryland		STREET ADDRESS (If rural give location) 1	

3. NAME OF DECEASED:		4. DATE (Month) (Day) (Year)	
(First) Lowell	(Middle) Franklin	(Last) KRIEG	OF DEATH: Nov 21 1956
5. SEX: M	6. COLOR OR RACE: Cauc	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married	8. DATE OF BIRTH: 9-9-29
9. AGE last birthday 27 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): U.S. Navy	10B. KIND OF BUSINESS OR INDUSTRY: U.S. Navy	11. BIRTHPLACE (State or foreign country): St. Louis, Missouri	12. CITIZEN OF WHAT COUNTRY?
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13. FATHER'S NAME: John M. Krieg	14. MOTHER'S MAIDEN NAME: Deceased
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) Yes	16. SOCIAL SECURITY NO. (If Yes, give war or dates of service) 3-5-47 to present	17. INFORMANT'S ADDRESS: Naval Powder Factory, Indian Head, Maryland
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18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
(A) IMMEDIATE CAUSE 782.4 Acute Cardio Respiratory Failure		1/2 hour
(B) ANTECEDENT CAUSE (S) Cause Unknown		
(C) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. No known prior serious illness	
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19A. DATE OF OPERATION: None	19B. MAJOR FINDINGS OF OPERATION: None	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
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21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY atreet, office bldg., etc.)	21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?
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21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from , 19, to , 19, that I last saw the deceased alive on 11-21-1956, and that death occurred at 11 P.M. from the causes and on the date stated above.

SIGNATURE DATE SIGNED 11-22-56  
M. D. J. P. NASOU, LT MC USNR

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Transhumation	DATE THEREOF 11/21/56	NAME OF CEMETERY OR CREMATORY Naval Hospital	LOCATION (City, town, or county) Bethesda, Montgomery Md.
DATE REC'D BY LOCAL REGISTRAR 11/21/56	REGISTRAR'S SIGNATURE Odey. Price	24. FUNERAL DIRECTOR ADDRESS	

MARGIN RESERVED FOR BINDING

VS. A15 — 10-3

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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NOV 28 1956

BUREAU V. L.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 11261 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11261

Reg. Dist. No. 100

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Charles</u> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Belair</u> c. LENGTH OF STAY IN 1b _____ d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) _____				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Hartford</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Belair</u> d. STREET ADDRESS <u>Phenixville Rd</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <u>Reuben</u> First <u>Brown</u> Middle <u>Maxwell</u> Last <b>4. DATE OF DEATH</b> Month <u>Nov</u> Day <u>27</u> Year <u>1956</u>				<b>5. SEX</b> <u>male</u> <b>6. COLOR OR RACE</b> <u>white</u> <b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>Oct 23, 1903</u> <b>9. AGE</b> (In years last birthday) <u>53</u> yrs. <b>IF UNDER 1 YEAR</b> Months <u>1</u> Days <u>4</u> <b>IF UNDER 24 HRS.</b> Hours _____ Min. _____			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Engineer</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>CTP Phone Co</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>MO</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>	
<b>13. FATHER'S NAME</b> <u>John T. Maxwell</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>9 Brown</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <input checked="" type="checkbox"/> <u>WW #2</u>		<b>16. SOCIAL SECURITY NO.</b> <u>212-10-0506</u>		<b>17. INFORMANT</b> Address <u>Ethel F Maxwell Belair Md</u>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary Occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO _____ (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>11-27-56</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) _____							
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) _____			
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour _____ a. m. _____ p. m. _____ 19 <u>56</u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) _____		<b>20f. (City or town)</b> _____ (County) _____ (State) _____	
<b>21. I certify that I took charge of the remains described above, held an Autopsy</b> <input type="checkbox"/> <b>Inspection</b> <input checked="" type="checkbox"/> <b>Inquiry</b> <input type="checkbox"/> <b>and find that death resulted from:</b> Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>							
<b>ACTUAL SIGNATURE</b> <u>E. J. EDELEN</u> <b>EXAMINER'S NAME (Type)</b> <u>E. J. EDELEN MD</u>				<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>			
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Church</u>				<b>22b. DATE THEREOF</b> <u>11/30/56</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Memorial Gardens</u>	
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Wickert Inc</u>				<b>ADDRESS</b> <u>La Plata</u>		<b>24a. REC'D BY REGISTRAR</b> <u>Julia H. Paray</u>	
<b>24b. REGISTRAR'S SIGNATURE</b> _____				<b>DATE</b> <u>11/29/56</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. S.

BUREAU V. S.

1

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11262

## 11269 CERTIFICATE OF DEATH

Reg. Dist. No. 100

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <i>Charles</i>		MARYLAND		STATE <i>Maryland</i>		COUNTY <i>Chas</i>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <i>La Plata</i>		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>RFD. La Plata</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Physical Memorial Hospital</i>				STREET ADDRESS (If rural give location) <i>Mason Springs</i>			
<b>3. NAME OF DECEASED</b> (Type or Print) <i>Everett E MILLARD</i>				<b>4. DATE OF DEATH</b> (Month) <i>Nov</i> (Day) <i>4</i> (Year) <i>1956</i>			
<b>5. SEX</b> <i>Male</i>	<b>6. COLOR OR RACE</b> <i>U.S.W.</i>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b>	<b>8. DATE OF BIRTH</b> <i>2 Nov 1867</i>	<b>9. AGE last birthday</b> <i>89</i> yrs.	<b>IF UNDER 1 YEAR</b> Months Days		<b>IF UNDER 24 HRS.</b> Hours Min.
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <i>Saw mill</i>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <i>Lumber</i>		<b>11. BIRTHPLACE</b> (State or foreign country) <i>Md.</i>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <i>USA</i>	
<b>13. FATHER'S NAME</b> <i>Addison MILLARD</i>				<b>14. MOTHER'S MAIDEN NAME</b> <i>Emma HOUSE</i>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) <i>NO</i> (If Yes, give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b> <i>NO</i>		<b>17. INFORMANT &amp; ADDRESS</b> <i>ORVILLE E MILLARD</i>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
<b>420.1 IMMEDIATE CAUSE</b> (A) <i>Cerebral occlusion</i>						<i>15 min</i>	
<b>ANTECEDENT CAUSE(S) DUE TO</b> (B) <i>Senile arteriosclerosis</i>						<i>39 years</i>	
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO</b> (C)							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b> <i>Basal Cell Carcinoma, face</i>						<i>39 years</i>	
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>					
<b>21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE</b> (Home, farm, factory, OF INJURY street, office bldg., etc.)		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town)		<b>(County) (State)</b>	
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) M.		<b>21e. INJURY OCCURRED</b> While et work <input type="checkbox"/> Not while et work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify</b> that I attended the deceased from <i>7:00 A.M.</i> , 19 <i>56</i> , to <i>4 Nov 56</i> , 19 <i>56</i> , that I last saw the deceased alive on <i>4 Nov 56</i> , and that death occurred at <i>2:15 P.M.</i> , from the causes and on the date stated above.							
<b>SIGNATURE</b> <i>Howard</i>				<b>ADDRESS</b> (Street, city, town, state) <i>La Plata Md.</i>		<b>DATE SIGNED</b> <i>5 Nov 56</i>	
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <i>Burial</i>				<b>DATE THEREOF</b> <i>11-7-56</i>		<b>NAME OF CEMETERY OR CREMATORY</b> <i>Manbury Baptist Cem</i>	
						<b>LOCATION</b> (City, town, or county) (State) <i>Manbury Md</i>	
<b>24. REC'D BY REGISTRAR</b>		<b>REGISTRAR'S SIGNATURE</b> <i>Julia Posey</i>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <i>Wm Hunt Funeral Home</i>		<b>ADDRESS</b> <i>La Plata Md</i>	
<b>DATE</b> <i>NOV 8 1956</i>							

# 1959 CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 19

Reg. Dist. No.

1. NAME OF DECEASED (Print or Write)

2. SEX (Male or Female)

3. AGE (Years and Months)

4. DATE OF BIRTH (Month, Day, Year)

5. PLACE OF BIRTH (City, State, Country)

6. OCCUPATION (Print or Write)

7. MARITAL STATUS (Single, Married, Widowed, Divorced)

8. DATE OF DEATH (Month, Day, Year)

9. PLACE OF DEATH (City, State, Country)

10. CAUSE OF DEATH (Print or Write)

11. MANNER OF DEATH (Natural, Accidental, Suicide, Homicide, Undetermined)

12. SIGNATURE OF PHYSICIAN (Print or Write)

13. SIGNATURE OF REGISTRAR (Print or Write)

14. SIGNATURE OF WITNESS (Print or Write)

15. SIGNATURE OF DECEASED (Print or Write)

16. SIGNATURE OF NEXT OF KIN (Print or Write)

17. SIGNATURE OF CLERK (Print or Write)

18. SIGNATURE OF CHURCH CLERK (Print or Write)

19. SIGNATURE OF BURIAL CLERK (Print or Write)

20. SIGNATURE OF CREMATOR (Print or Write)

21. SIGNATURE OF OTHER (Print or Write)

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40. SIGNATURE OF OTHER (Print or Write)

BUREAU V. S.

NOV 8 1956

RECEIVED

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## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11263

## 11270 CERTIFICATE OF DEATH

Reg. Dist. No. 100

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>CHARLES</u>		MARYLAND		STATE <u>MARYLAND</u>		COUNTY <u>CHARLES</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Rural</u>		LENGTH OF STAY (In this place) <u>Lifetime</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Rural</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Grayton.</u>				STREET ADDRESS (If rural give location) <u>Grayton.</u>			
<b>3. NAME OF DECEASED</b> (Type or Print) <u>WALTER</u> (First) <u>MILLS</u> (Middle) (Last)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <u>NOV 26</u> 19 <u>56</u>			
5. SEX <u>M.</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>	8. DATE OF BIRTH <u>June 18-1899</u>		9. AGE last birthday <u>64</u> yrs.		IF UNDER 1 YEAR Months Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Grayton md</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Conchious R Mills</u>				14. MOTHER'S MAIDEN NAME <u>Katherine</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Mary Perryman Mills</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
1420.1 IMMEDIATE CAUSE (A) <u>Coronary thrombosis</u>						<u>15 min.</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Coronary artery disease</u>						<u>6 min.</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) M. <input type="checkbox"/> at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21i. HOW DID INJURY OCCUR?					
<b>22. I hereby certify that I attended the deceased from</b> <u>May</u> , 19 <u>49</u> , <b>to</b> <u>Nov 26</u> , 19 <u>56</u> , <b>that I last saw the deceased alive on</b> <u>26 Nov</u> , 19 <u>56</u> , <b>and that death occurred at</b> <u>5:15 PM</u> , <b>from the causes and on the date stated above.</b> <b>SIGNATURE</b> <u>Dr. Wooddy</u> <b>M.D.</b> <u>La Plata Md.</u> <b>DATE SIGNED</b> <u>26 Nov 56</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>11-29-56</u>		NAME OF CEMETERY OR CREMATORY <u>Arlington Memorial Cemetery Arlington Va</u>		LOCATION (City, town, or county) (State) <u>La Plata Md</u>	
24. REC'D BY REGISTRAR <u>11/29/56</u>		REGISTRAR'S SIGNATURE <u>Julia H. Parry</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Archie D. Inc La Plata Md</u>		ADDRESS	



# CERTIFICATE OF DEATH

Form No. 10-1

1. NAME OF DECEASED

2. SEX

3. AGE

4. DATE OF BIRTH

5. PLACE OF BIRTH

6. OCCUPATION

7. CAUSE OF DEATH

8. PLACE OF DEATH

9. TIME OF DEATH

10. SIGNATURE OF PHYSICIAN

11. SIGNATURE OF REGISTRAR

12. SIGNATURE OF WITNESSES

13. SIGNATURE OF DECEASED

14. SIGNATURE OF NEXT OF KIN

15. SIGNATURE OF BURIAL OFFICIAL

16. SIGNATURE OF CHURCH OFFICIAL

17. SIGNATURE OF MINISTER

18. SIGNATURE OF CLERGYMAN

19. SIGNATURE OF RABBI

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NOTIFICATION

1. NAME OF DECEASED  
2. SEX  
3. AGE  
4. DATE OF BIRTH  
5. PLACE OF BIRTH  
6. OCCUPATION  
7. CAUSE OF DEATH  
8. PLACE OF DEATH  
9. TIME OF DEATH  
10. SIGNATURE OF PHYSICIAN  
11. SIGNATURE OF REGISTRAR  
12. SIGNATURE OF WITNESSES  
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INSTRUCTIONS  
TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.  
VS A15C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

## 11271 CERTIFICATE OF DEATH

11264

Reg. Dist. No. 100

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <u>CHARLES</u>	MARYLAND	STATE <u>New York</u>	COUNTY <u>✓</u>
CITY (If outside corporate limits, write RURAL or end give nearest town) <u>LA PLATA</u>	LENGTH OF STAY (In this place) <u>5 days</u>	CITY (If outside corporate limits, write RURAL and give nearest town) <u>Waterbury N.Y.</u>	TOWN <u>Waterbury N.Y.</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>PHYSICIANS MEMORIAL HOSP.</u>		STREET ADDRESS (If rural give location) <u>69X-3</u>	
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH	
(First) <u>LOYAL</u> (Middle) <u>EDWARD</u> (Last) <u>PRAIRIE</u>		(Month) <u>11</u> (Day) <u>11</u> (Year) <u>1956</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>M</u>	8. DATE OF BIRTH <u>Oct 27 1891</u>
9. AGE last birthday <u>65</u> yrs.		10. IF UNDER 1 YEAR (Months) <u>11</u> Days <u>11</u> IF UNDER 24 HRS. (Hours) <u>19</u> Min. <u>56</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Engineer RET Rail Road</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Cherry N.Y.</u>	
11. BIRTHPLACE (State or foreign country) <u>Cherry N.Y.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Edward</u>		14. MOTHER'S MAIDEN NAME <u>Prairie Delia Lucia</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>7-14-10-9920</u>	
17. INFORMANT & ADDRESS <u>Ethel R Prairie N.Y.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	
420.1 IMMEDIATE CAUSE (A) <u>CORONARY OCCLUSION</u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 MIN.</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>"</u>		<u>INSUFFICIENCY</u> <u>6 MOS</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>Previous Coronary</u>		<u>7 years</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) <u>M.</u> <u>White</u> <input type="checkbox"/> <u>Not white</u> <input type="checkbox"/> <u>et work</u> <input type="checkbox"/> <u>et work</u> <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>11-7</u> , 19 <u>56</u> , to <u>11-11</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>11-11</u> , 19 <u>56</u> , and that death occurred at <u>2:05 PM</u> from the causes and on the date stated above.			
SIGNATURE <u>F. M. Johnson</u>		DATE SIGNED <u>11-11-56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Ship to</u>		DATE THEREOF <u>Nov 11 1956</u>	
NAME OF CEMETERY OR CREMATORY <u>Bartel Funeral Home</u>		LOCATION (City, town, or county) <u>Sathome N.Y.</u>	
24. REC'D BY REGISTRAR <u>Julia H. Paresy</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Archant Funeral Home Inc</u>	
DATE <u>12/13/56</u>		ADDRESS <u>La Plata Md.</u>	

RECEIVED

Reg. Dist. No. 107

1. PLACE OF DEATH a. COUNTY <u>Charles</u>		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>Chas</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Nanjemoy</u>		c. LENGTH OF STAY IN 1b <u>7</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Nanjemoy</u>		d. STREET ADDRESS <u>Nanjemoy</u>	
3. NAME OF DECEASED (Type or print) <u>Nora</u>		4. DATE OF DEATH Month <u>11</u> Day <u>16</u> Year <u>1956</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>FEB. 31, 1887</u>
9. AGE (In years last birthday) <u>69</u> yrs.		10. UNDER 1 YEAR Months <u>11</u> Days <u>16</u> Hours <u>19</u> Min. <u>56</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>MASSENA KENDRICK</u>		14. MOTHER'S MAIDEN NAME <u>JANES RYE</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>Frank Rye Nanjemoy MD</u>	
17. INFORMANT <u>Frank Rye Nanjemoy MD</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Occlusion</u> (c) <u>Ben Art Sclerosis</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <u>o. m.</u> <u>p. m.</u> <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>E. J. Edelen</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>E. J. EDELEN MD</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>11-16-56</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>		22b. DATE THEREOF <u>Nov 18 1956</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Nanjemoy Baptist</u>		22d. LOCATION (City, town, or county) (State) <u>Nanjemoy MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hunt Funeral Home</u>		24a. REC'D BY REGISTRAR <u>NOV 20 1956</u>	
24b. REGISTRAR'S SIGNATURE <u>John Thompson</u>			

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your use.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or entombment.

STATE OF NEW YORK  
 DEPARTMENT OF HEALTH - BUREAU OF  
 MEDICAL EXAMINERS & CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH		PLACE OF DEATH	
JAMES J. JONES		45		M		W		11-22-66		NEW YORK	
MANNER OF DEATH		CAUSE OF DEATH		DISEASE		INJURY		TOXIC		OTHER	
Suicide		Heart Disease		Myocardial Infarction							
Signature of Medical Examiner		Signature of Coroner		Signature of Registrar		Signature of Burial Officer		Signature of Undertaker		Signature of Funeral Home	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	

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 BUREAU V. 3

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed with the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55

11273 Items 7,14 FilmG207 11-26-56 et  
Item 9 FilmG207 11-26-56 et  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
11266  
CERTIFICATE OF DEATH

Reg. Dist. No. 105

1. PLACE OF DEATH a. COUNTY <u>CHAS</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WALDORF</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>CHAS</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WALDORF</u> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>FRED S SCHWAB</u> First Middle Last 5. SEX <u>M</u> 6. COLOR OR RACE <u>W</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>Nov 18, 1868</u> 9. AGE (In years last birthday) <u>87</u> yrs. IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS. Months Days Hours Min.		4. DATE OF DEATH <u>Nov 17 1956</u> Month Day Year	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>FARMING</u> 11. BIRTHPLACE (State or foreign country) <u>WASHINGTON DC</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13. FATHER'S NAME <u>CONRAD SCHWAB</u> 14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) 16. SOCIAL SECURITY NO. 17. INFORMANT <u>FRED S SCHWAB</u> Address <u>WALDORF MD</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIAC FAILURE</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>CORONARY ARTERIOSCLEROSIS</u> DUE TO (c) <u>CEREBLOSCLEROSIS</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u> 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		21. I certify that I attended the deceased from <u>SEPTEMBER 28, 1956</u> , to <u>NOVEMBER 17, 1956</u> , that I last saw the deceased alive on <u>NOVEMBER 17, 1956</u> , and that death occurred at <u>9:10 A.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>Paul Chen</u> M.D. <u>ACCOKEEK, MD.</u> <u>11-17-56</u> ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) <u>PAUL CHEN, M.D.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 22b. DATE THEREOF <u>Nov 20, 1956</u> 22c. NAME OF CEMETERY OR CREMATORY <u>Prospect Hill Cemetery</u> 22d. LOCATION (City, town, or county) (State) <u>Washington D. C.</u>		23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>F. Gasch's Sons Hyattsville, Md.</u> 24a. REC'D BY REGISTRAR DATE <u>NOV 20 1956</u> 24b. REGISTRAR'S SIGNATURE <u>M. L. Monroe</u>	



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BUREAU V. S.

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**11274 MEDICAL EXAMINER'S CERTIFICATE OF DEATH**  
 Reg. Dist. No. **100**

1. PLACE OF DEATH a. COUNTY <b>Charles</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Charles</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Benadict</b>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Benadict</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) <b>JULIAN</b> First <b>HOWARD</b> Middle <b>WASHINGTON</b> Last				4. DATE OF DEATH Month <b>11</b> Day <b>2</b> Year <b>1956</b>			
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Mar. 8, 1894</b>		9. AGE (In years last birthday) <b>62</b> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Auditor</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Esso-Service</b>		11. BIRTHPLACE (State or foreign country) <b>Alexandria,</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>	
13. FATHER'S NAME <b>Lawrence Washington</b>				14. MOTHER'S MAIDEN NAME <b>Fannie Lackland</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b> (If yes, give war or dates of service) <b>World War 1</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mrs. Edna D. Washington, Benadict, Md.</b> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carbon monoxide poisoning</b> 973.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>athaust from auto</b> DUE TO (c) <b>Suicide</b> INTERVAL BETWEEN ONSET AND DEATH <b>11-2-56</b> <b>11-2-56</b> <b>11-2-56</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>11-2-1956</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>Benadict</b> (County) <b>Charles</b> (State) <b>Md</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>E. J. EDELEN</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>11-3-56</b>			
EXAMINER'S NAME (Type) <b>E. J. EDELEN</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Nov. 6/56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Arlington</b>		22d. LOCATION (City, town, or county) (State) <b>Arlington, Va.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. S. Everly, Alexandria, Va.</b>				24a. REC'D BY REGISTRAR DATE <b>11/6/56</b>		24b. REGISTRAR'S SIGNATURE <b>Julia H. Porey</b>	

MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU 12  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

RECEIVED  
NOV 8 1956  
BUREAU V. 2

Name of Deceased		Sex		Age		Date of Death	
Lawrence Washington		Male		38		Nov 3, 1956	
Residence		Place of Birth		Cause of Death		Manner of Death	
Boston, Mass.		Boston, Mass.		Heart Disease		Natural	
Occupation		Education		Marital Status		Previous Illnesses	
None		High School		Married		None	
Signature of Medical Examiner		Signature of Coroner		Signature of Registrar		Signature of Burial Officer	
J. B. Dwyer, M.D.		J. B. Dwyer, M.D.		J. B. Dwyer, M.D.		J. B. Dwyer, M.D.	